PRINTED: 09/27/2012 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414	B. WIN				C 4/2012
	NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE		I	10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE AINTSVILLE, KY 41240	04/0-	4/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	An abbreviated surve on 03/30/12 and com complaint was substated were cited at a scope CFR 483.20 Resident CFR 483.25 Quality of 483.75 Administration Quality of Care at 42. The facility failed to hensure adequate supprevent accidents for residents (Resident # assessed by the facility behaviors and was at the facility without state was admitted to the lost staff was to monitor the provide diversion active exhibited wandering to 12:53 PM, the communication of the courtyard gate was supported by the facility power. On 03/15/12, Unit's back door at 12 courtyard, and exited PM. Two staff members.	ey (KY18096) was initiated pleted on 04/04/12. The intiated and deficiencies and severity of "J" at 42 to Assessment (F282), 42 of Care (F323), and 42 CFR in (F490), with Substandard CFR 483.25 Quality of Care. ave an effective system to ervision and monitoring to one of nine sampled 1). Resident #1 was		000			
	facility at 1:06 PM, eigresident had exited the	unharmed, back inside the ght minutes after the					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u> :		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414	B. WIN	G		04/04	2 4/2012
	OVIDER OR SUPPLIER	LLE	•	10	EET ADDRESS, CITY, STATE, ZIP CODE 125 EUCLID AVENUE AINTSVILLE, KY 41240		.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000	State Agency's invest	rective actions prior to the igation on 03/30/12; dy was determined to be		282			
	PERSONS/PER CAR The services provided must be provided by o	E PLAN I or arranged by the facility					
	by: Based on interview, of and review of facility puthe facility failed to hat ensure services were with each written compone of nine sampled in The facility assessed wandering behaviors facility without staff's placed Resident #1 in was to monitor and do behaviors and provide the resident exhibited 03/15/12, a citywide putween the hours of The alarms to the backed Unit and the codeactivated. Review facility's video recording exited through the backed Unit was carin	ourtyard gate were			Past noncompliance: no plan of correction required.		

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		185414	A. BUILDING C 185414					
	OVIDER OR SUPPLIER	LLE		10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE AINTSVILLE, KY 41240	J 04/3	72012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE				
F 282	Resident #1 exited the The video surveillance members (Stock Con Activities Director) states 1:04 PM, observed Regrassy area behind the Resident #1 back insidocumentation on the reports and a review assisted Resident #1 1:06 PM, eight minute facility. Interviews revealed faback door of the unite not connected to the power during power of the facility's failure to place to ensure service accordance with each care was likely to cause impairment, or death, was determined to excontinued until 03/29/corrective actions pricinvestigation on 03/30 was determined to be the facility Prevention Policy (revention Policy (revention Policy) (rev	e courtyard gate at 1:01 PM. e revealed two staff trol #1 and Assistant anding outside the facility at esident #1 walking in the ne facility, and ran to assist de the facility. Based on e incident and investigation of video footage, facility staff back inside the facility at es after the resident left the acility staff was unaware the and the courtyard gate were generator for emergency outages. The have an effective system in ces were provided in individual's written plan of se serious injury, harm, The Immediate Jeopardy ist on 03/15/12, and 12. The facility completed or to the State Agency's 0/12; therefore, the Jeopardy e Past Jeopardy. The Wander/Elopement vised on 01/23/12) revealed threat to leave the facility onfusion, without the	F	282				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
405444			A. BUILDING			С	
		185414	B. WING			04/04/2012	
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE		1025	FADDRESS, CITY, STATE, ZIP CODE EUCLID AVENUE NTSVILLE, KY 41240	-	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				LD BE	(X5) COMPLETION DATE	
F 282	developed and impleid Review of the Missing 03/06/12) revealed all adequate supervision. A review of an incider dated 03/15/12 reveal occurred between the 4:04 PM. The report the courtyard gate were emergency generator alarms during the power port, Resident #1 ethe staff. Documental staff assigned to work Certified Nurse Aide (Licensed Practical Nurse Aide) Licensed Practical Nurse Aide (Licensed Practical Nurse Aide) Exited the courtyard of members (Stock Con Activities Director) were facility at 1:04 PM, and walking in the grassy assisted Resident #1 residential area was refeet away from the grassident was located. On the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage, facil #1 back inside the facility at 1:04 PM and the incident/invest of video footage and the incident facility at 1:04 PM and the incident facility at 1:04 PM and the incident facility at 1:04 PM and the incident facility at 1:04	presented for those residents. g Persons policy (revised I residents should receive to prevent elopement. Int and investigation report led a citywide power outage hours of 12:43 PM and revealed the Unit door and the power and were without ever outage. Based on the wited the facility unnoticed by tion in the report revealed to the Unit on 03/05/12, (CNA) #1, CNA #2, and urse (LPN) #1, was in the facility. A review of the erevealed Resident #1 pate at 1:01 PM, two staff trol #1 and Assistant ere standing outside the dobserved Resident #1 area behind the facility. A noted to be approximately 20 assy area where the Based on documentation igation reports and a review ity staff assisted Resident cility at 1:06 PM, eight dent left the facility	F2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIP _DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414	B. WIN	G			C 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE	•	10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 282	and Severe Impairme known risk for elopem assigned to the locked care plan developed of facility would monitor behaviors. The care 03/12/12 to include R wandering toward exithe exit doors, and stathome. Facility staff in for getting to a potent the facility. Intervention revealed staff was to behaviors, alert staff wandering behavior, papproach the resident times, and redirect the care plan indicated if from the Unit, staff was converse, and gently walk back to the design addition, the plan reveal elopement protocol, rowhen leaving the desiresident, and that Soot the resident on an "as A comprehensive adruging the desiresident on an "as A comprehensive adruging the desiresident on outless occurred desiresident's diagnosis at the MDS Coordinator diagnosis of Dementication of the service of the modern of the plan resident's diagnosis at the MDS Coordinator diagnosis of Dementication.	ant. Resident #1 was a ment from home and was d Unit. A comprehensive on 03/08/12 revealed the Resident #1's wandering plan was revised on esident #1's behaviors of t doors, trying to get out of ating he/she was going oted the resident was at risk itally unsafe area or out of ons on the revised care plan monitor the resident exhibited provide diversion activities, t in a calm manner at all the resident "as needed." The Resident #1 wandered away as to stay with the resident, persuade the resident to gnated areas with them. In ealed staff was to follow the emind visitors to inform staff ignated area with the sial Services was to evaluate a needed" basis. Inission assessment dated sident #1's wandering aily. Jumum Data Set (MDS) July 12, at 1:45 PM, revealed alans based on each and conditions. According to	F	282			

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			B. WING			C 04/04/2012		
	NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			102	ET ADDRESS, CITY, STATE, ZIP CODE 25 EUCLID AVENUE LINTSVILLE, KY 41240	04/0	4/2012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			LD BE	(X5) COMPLETION DATE			
F 282	closely. In addition, to Resident #1 was ident wandering /elopement developed that including resident's wandering resident activities as a resident's family ment to sit with the resident protocols if the resident protocols if the resident staff knowledge. A review of the nursing 1:00 PM, in Resident revealed LPN #1, CN resident's room located #1 exited the facility a staff's knowledge. But the nursing notes, Resident's room located #1 exited the facility by staff, was injuries, was in no dismonitored. Interviews conducted and #5 on 04/02/12, and AM, 10:25 AM, 11:30 LPNs #1, #2, #3, and 2:55 PM, 3:00 PM, ar Maintenance Director revealed they were an assessed to exhibit when behaviors and were known interventions to imple eloped from the facility stated they checked thours on their shift to functioning properly and the side of the side of the stated they checked the stated they checked the side of the sid	the MDS Coordinator stated titified to be at risk for the Interventions were ed alerting staff of the behaviors, offering the adversion, calling the obers to come to the facility without the obers to come to the facility without the obers of the obers	F	282				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
185414			B. WING			C 04/04/2012	
	NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			102	ET ADDRESS, CITY, STATE, ZIP CODE 25 EUCLID AVENUE INTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	immediately reported Administration. Howe not know the back do gate to the Unit were power. The nurses a developed by the nurset (MDS) Coordinate there were changes in addition, staff interview were developed and/ocarried by all CNAs. included information reach resident. Interview with the Adradministrator, and the 03/30/12, at 10:35 An administrative staff krelopement risk, was a locked Unit, and was the plan of care. The unaware the back do the courtyard was not power, leaving the do alarms during a power Interview with Reside 03/30/12, at 10:30 An resident's severely im no memory of the elo Resident #1 on 03/30 AM, and on 04/02/12 11:30 AM, revealed s supervision of the res resident throughout the therapies, and the directions and the direction of the resident throughout the therapies, and the direction of the resident throughout the therapies, and the direction of the resident throughout the therapies, and the direction of the resident throughout the therapies, and the direction of the resident throughout the therapies, and the direction of the resident throughout the therapies, and the direction of the resident throughout the therapies of the therapies of the throughout the therapies, and the direction of the resident throughout the therapies of the throughout the throug	to Maintenance and ever, staff revealed they did or of the Unit and courtyard not on emergency generator iso stated care plans were sees and the Minimum Data ors and were updated when in a resident's condition. In the waste and the CNA care plans or updated by nurses and the CNA care plans or updated by nurses and the CNA care plans or updated to care provided for the Director of Nursing on the elated to care provided for the Waste and the new Resident #1 was an assigned a room in the to be monitored closely, per administrative staff was for of the Unit or the gate to the elate to th	F	282			

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		185414	B. WIN	IG_		C 04/04/2	
	OVIDER OR SUPPLIER	LLE	<u> </u>	1	REET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	, , , , , , , , , , , , , , , , , , , 	72012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	incident on 03/15/12, member came to the #1 until the power was -Resident #1 was place supervision on 03/15/one supervision on 03/15/one supervision. -Resident #1's physice on 03/15/12 of the incompart of the intervision of Resides. -The Medical Director on 03/15/12 and updated supervision of Resides. -The care plans of the intervised as needed to -An investigation was Assistant Administrate Nursing (DON), and Metermine how Reside 03/15/12. -The AADM continuous back door and the contact of the position of the position of the position was Assistant Administrate Nursing (DON), and Metermine how Reside 03/15/12.	member was notified of the at 1:10 PM, and the family facility to sit with Resident is restored. Deed on one to one 12 and remains on one to 12 and remains on one to 12 and remains on one to 13 and remains on one to 14 sident and no new orders facility. The was notified of the incident 15 and was reviewed on 16 to include one to one and 17 and the incident 18 and the incident 19 an	F	282			
	7 ti iii-30 vioe regalui	ng what to do in the event of					

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	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE	I	10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE PAINTSVILLE, KY 41240	1 04/0-	472012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	a power outage in the with all staff working included close monitor residents per the plant. -A sign was posted on in the Unit on 03/15/12 electricity goes out, the residents should be residents and state of the Unit in order to have energency generator. -All exit doors and state were checked on 03/found to be locked, a properly on generator door to the Unit and the Unit does not be should	e Unit was held on 03/15/12 on the unit. The in-service oring of elopement risk in of care. In the medication room door 2 to inform staff that "if the ne doors will unlock and the monitored closely." In the local power company utage on 03/15/12, at 1:15 In the medication room door 2 to inform staff that "if the ne doors will unlock and the monitored closely." In the medication room door 2 to inform staff that "if the ne doors will unlock and the nonitored closely." In the medication room door 2 for other licensed nursing lid not work in the Unit but	F	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185414	B. WIN	G				
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F 282	will be monitored ever staff and the results or reported quarterly at the committee met on 03/1 review care plans and a connected to the power on 03/30/12 to functional in the even outage. This was sch Maintenance Director the surveyor validate taken by the facility as a clinterview with the Adadministrator (AADM (DON) on 03/30/12, and Assistant Administrated door and courtyard gap PM, until power was reported in the was restored on 03/15/12 -Review of Resident frevisions were made the incident on 03/15/10:30 AM and 11:30 Am provided one to one sand escorted the residence and courted the residence and escorted the residence and escorted the residence and courted the residence and escorted the residence and escorte	ry two hours by the nursing If the monitoring will be the CQI meetings. The CQI In 15/12 and 03/28/12 to I policies. Unit and the courtyard gate the emergency generator the ensure locks/alarms were the of an electrical power the duled on 03/15/12 by the the the corrective action to follows: ministrator, Assistant the properties of Nursing the 10:25 AM, revealed the the promonitored the Unit's back the from 03/15/12, at 1:06 the testored on 03/15/12, at 4:04 the review with LPN #1 on the confirmed the fact that the Unit door until the power to the care plan confirmed to the care plan following	F	282				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, 2IP CODE 1029 EUCLID AVENUE PAINTSVILLE, RY 9129 EUCLID A	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE SUMMARY STATEMENT OF DEFICIENCIES PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 10 Interview with the AADM on 04/03/12, at 4:00 PM, and a review of documentation in resident care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans and the "wandering/elopement" book the substantial of the AADM, the "wandering leopement" book was reviewed for all residents assessed to be at risk for elopement-wandering behaviors, with updated pictures, personal identification, and room numbers. -A review of in-service provided for staff working the Unit on 03/15/12 revealed staff was to closely monitor residents assessed by the facility to be at risk for wandering/elopement and were to monitor the back door of the Unit and the courtyard gate in the event of a power outage because the doors would not lock and/or alarm. In-services continued on 03/28/12 and 03/29/12 for staff that did not routinely work the Unit but could potentially be assigned to work in the Unit. Interviews with CNAs #1, #2, #3, #4, #5, #6, #7,#8, and #9, and LPNs #1, #2, #3, and #4 on 04/02/12, at 9.05 AM, 93.0 AM, 10.25 AM, 11.30						<u></u>	(0
MOUNTAIN MANOR OF PAINTSVILLE SUMMARY STATEMENT OF DEFICIENCIES PREFIX REQULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 10 Interview with the AADM on 04/03/12, at 4:00 PM, and a review of documentation in resident care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans were reviewed and checked for accuracy (Residents #1, #2, #4, #5, #6, #7, #8, and #9). No discrepancies were found with the elopement wandering behaviors, with updated pictures, personal identification, and room numbers. -A review of in-service provided for staff working the Unit on 03/15/12 revealed staff was to closely monitor residents assessed by the facility to be at risk for wandering/elopement and were to monitor the back door of the Unit and the courtyard gate in the event of a power outage because the doors would not lock and/or alarm. In-services continued on 03/28/12 and 03/29/12 for staff that did not routinely work the Unit but could potentially be assigned to work in the Unit. Interviews with CNAs #1, #2, #3, #4, #5, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #5, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #1, #2, #3, #4, #6, #6, #7, #8, and #9, and LPNs #			185414	B. WIN	<u> </u>		04/0	4/2012
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 10 -Interview with the AADM on 04/03/12, at 4:00 PM, and a review of documentation in resident care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans were reviewed and checked for accuracy (Residents #1, #2, #4, #5, #6, #7, #8, and #9). No discrepancies were found with the elopement care plans. According to the AADM, the "wandering/elopement" book was reviewed for all residents assessed to be at risk for elopement/wandering behaviors, with updated pictures, personal identification, and room numbers. -A review of in-service provided for staff was to closely monitor residents assessed by the facility to be at risk for wandering/elopement and were to monitor the back door of the Unit and the courtyard gate in the event of a power outage because the doors would not lock and/or alarm. In-services continued on 03/28/12 and 03/29/12 for staff that did not routinely work the Unit but could potentially be assigned to work in the Unit. Interviews with CNAs #1, #2, #3, #4, #5, #6, #7, #8, and #9, and LPNs #1, #2, #3, and #4 on 04/02/12, at 9:05 AM, 9:30 AM, 10:25 AM, 11:30		MOUNTAIN MANOR OF PAINTSVILLE			10	025 EUCLID AVENUE		
-Interview with the AADM on 04/03/12, at 4:00 PM, and a review of documentation in resident care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans were reviewed and checked for accuracy (Residents #1, #2, #4, #5, #6, #7, #8, and #9). No discrepancies were found with the elopement care plans. According to the AADM, the "wandering/elopement" book was reviewed for all residents assessed to be at risk for elopement/wandering behaviors, with updated pictures, personal identification, and room numbers. -A review of in-service provided for staff working the Unit on 03/15/12 revealed staff was to closely monitor residents assessed by the facility to be at risk for wandering/elopement and were to monitor the back door of the Unit and the courtyard gate in the event of a power outage because the doors would not lock and/or alarm. In-services continued on 03/28/12 and 03/29/12 for staff that did not routinely work the Unit but could potentially be assigned to work in the Unit. Interviews with CNAs #1, #2, #3, #4, #5, #6, #7,#8, and #9, and LPNs #1, #2, #3, and #4 on 04/02/12, at 9:05 AM, 9:30 AM, 10:25 AM, 11:30	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETION
O4/03/12, at 2:15 PM, 2:25 PM, 2:45 PM, 2:55 PM, 3:00 PM, and 3:10 PM respectively, revealed staff had been in-serviced and informed the back door of the Unit and the courtyard gate would not lock or alarm in the event of a power outage and should be monitored if a power outage occurred. In addition, staff interviewed acknowledged residents at risk for elopement were to be closely monitored at all times, including when a power		-Interview with the AAP PM, and a review of care plans and the "wrevised on 03/15/12 race plans were review accuracy (Residents and #9). No discrepate elopement care plans the "wandering/elope for all residents assess elopement/wandering pictures, personal idenumbers. -A review of in-service the Unit on 03/15/12 monitor residents asserisk for wandering/elothe back door of the Unit ne event of a power would not lock and/or continued on 03/28/13 did not routinely work potentially be assigned Interviews with CNAs #7,#8, and #9, and LF 04/02/12, at 9:05 AM, AM, 12:25 PM, 1:30 F 04/03/12, at 2:15 PM, PM, 3:00 PM, and 3:13 staff had been in-serviced in addition, staff interviewing the residents at risk for elements.	ADM on 04/03/12, at 4:00 documentation in resident vandering/elopement" book evealed all elopement risk ewed and checked for #1, #2, #4, #5, #6, #7, #8, ancies were found with the s. According to the AADM, ment" book was reviewed essed to be at risk for g behaviors, with updated entification, and room e provided for staff working revealed staff was to closely essed by the facility to be at appement and were to monitor Unit and the courtyard gate er outage because the doors alarm. In-services 2 and 03/29/12 for staff that the Unit but could ed to work in the Unit. #1, #2, #3,#4, #5, #6, PNs #1, #2, #3, and #4 on 9:30 AM, 10:25 AM, 11:30 PM, and 2:00 PM, and on 9:2:25 PM, 2:45 PM, 2:55 IO PM respectively, revealed viced and informed the back the courtyard gate would not event of a power outage and if a power outage occurred. Viewed acknowledged lopement were to be closely	F	282	DEFICIENCY)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIP _DING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414	B. WIN	G		04/04	2 4/ 2012
	OVIDER OR SUPPLIER	LLE	<u> </u>	1	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE PAINTSVILLE, KY 41240	04/0-	+/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 282	Administrator on 04/0 meetings had been he staff (Administrator, A Director of Nursing, M Coordinator, and Soc 03/15/12, 03/16/12, a plans for Resident #1 assessed to be at risk behaviors and to ensimplemented. The Administrative staff/C revised, and created content and training, a staff to document that courtyard gate locks/a functioning. -Reviews of the Door the facility on 03/15/1 (revised by the facility Wander/Elopement P by the facility on 03/15 no concerns identified 483.25(h) FREE OF A HAZARDS/SUPERVI	inutes and interview with the 4/12, at 11:00 AM, revealed eld with the Administrative assistant Administrator, linimum Data Set (MDS) ial Services Director) on and 03/28/12 to review care and other residents for wander/elopement are care plans were dministrator also stated the QI committee reviewed, policies, reviewed in-service and developed forms for a the Unit door and the alarms were monitored and Alarm Policy (reviewed by 2), Missing Persons Policy on 03/15/12), and revention Policy (reviewed 5/12) were conducted with d. ACCIDENT SION/DEVICES		282			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPL DING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414	B. WING				C 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE		10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE AINTSVILLE, KY 41240	,	<u>.</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	by: Based on interview, it the facility's investigatit was determined the effective system to er and monitoring to prenine sampled residen. The facility assessed and eight other reside wandering and eloped without staff knowled, was in the locked Unito monitor and docum 03/15/12 at 12:53 PM the facility, experience door alarm system in door and the courtyar not supported by the generator power. On exited the Unit's back the gated courtyard, at 1:01 PM. Two staff facility at 1:04 PM, an walking in a grassy at staff assisted Resider inside the facility at 1: the resident had exited in the resident facility staff returned in the courty of the grant of the resident facility staff returned in the resident facility staff returned in the courty of the grant of the resident facility staff returned in the courty of the grant of the resident facility staff returned in the courty of the grant of the	record review, and review of tion and the facility's policy, facility failed to have an asure adequate supervision went accidents for one of ts (Resident #1). and identified Resident #1 that to be at risk for ment (leaving the facility ge) behaviors. Resident #1 to of the facility and staff was tent resident behaviors. On the community, including the locked Unit to the back digate was deactivated and facility's emergency 03/15/12, Resident #1 door at 12:58 PM, went into and exited the courtyard gate of members were outside the digate observed Resident #1 the behind the facility. The ant #1, unharmed, back 06 PM, eight minutes after	F3	323	Past noncompliance: no plan of correction required.		

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	OF DEFICIENCIES F CORRECTION	` IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER			A. BUIL	DING		С		
		185414	B. WING	G		04/04/2012		
	ROVIDER OR SUPPLIER	VILLE		1025 E	DDRESS, CITY, STATE, ZIP CODE UCLID AVENUE SVILLE, KY 41240	•		
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F 323	place to ensure ade monitoring for resid-wandering/elopeme cause serious injury. The Immediate Jeo on 03/15/12, and co facility completed of State Agency's investherefore, the Jeopa Past Jeopardy. The findings include Review of the facility Prevention Policy (round "Residents who are unattended, due to knowledge of the facility and a pideveloped and implessed policy was to ensure the least restrictive further revealed state whereabouts of Green' for residents at risk for According to the poleave the facility, the Green' over the intesthe resident's room	to have an effective system in equate supervision and ents who were at risk for nt behaviors was likely to harm, impairment, or death. pardy was determined to exist entinued until 03/29/12. The corrective actions prior to the stigation on 03/30/12; andy was determined to be E: E: E: E: E: E: E: E: E: E	F3	323				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	(X3) DATE SUF	ĒD
		185414	B. WIN	G			2 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE		102	EET ADDRESS, CITY, STATE, ZIP CODE 25 EUCLID AVENUE AINTSVILLE, KY 41240	0-7/0-	72012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	until the staff determi longer an immediate Review of the Door A revealed nurses were shift change to assur stairwells were armed not locked and armed and armed immediate Administration were to the Review of the Missing 03/06/12) revealed all adequate supervision. Review of the facility book revealed the residents, including risk for wandering an located in each depale each nursing station. Pictures of the residents and room incresidents in the An incident and investigation of the power outage between and 4:04 PM, and the generated power was report revealed the U gate were not on the unlocked, and were wower outage. According to the power outage of the power outage of the power outage. Accordingly the power outage of the power outage of the power outage. Accordingly the power outage of the power outage of the power outage. Accordingly the power outage of the power outage of the power outage of the power outage. Accordingly the power outage of the power outage of the power outage of the power outage.	staff would conduct esident every 15 minutes ned the resident was no risk for elopement. Idarm Policy dated 04/06/09 e to make walking rounds at e all the exit doors and d and locked. If a door was d, the door was to be locked ely and Maintenance and o be informed. Ig Persons policy (revised Il residents should receive in to prevent elopement. Is "wandering/elopement" cility had assessed a total of ing Resident #1, as being at d/or elopement. A book was rement of the facility and at Each book included ints, identifying information of om numbers for each of the book. Stigation report dated e facility experienced a en the hours of 12:53 PM	F	323			

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		185414	B. WIN	WING 0		04/04	2 4/ 2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		025 EUCLID AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 323	12:58 PM, went into the through the courtyard report revealed the the to the unit were in and time Resident #1 exite by staff. Continued resurveillance revealed Control #1 and the Asserie outside the facility Resident #1 walking it facility, and assisted facility, and assisted facility at 1:06 PM (eigresident exited the lock video surveillance reversident exited the lock video surveillance reversider away from the grand resident #1 and diagnosis of Alzheir assessed the resident impaired. In addition, #1 had a history of elect A comprehensive cand 03/08/12 revealed the resident's behaviors, implemented on 03/12 risk of elopement as exwandering toward exit the exit doors, and stathome. Staff also asserisk for getting to a poof the facility. Interveresident's care plan in staff of the resident's provide the resident's provide the resident vapproach the resident vapproach the resident vapproach the resident in the staff of the resident vapproach the resid	the courtyard, and exited gate at 1:01 PM. The ree staff members assigned other resident's room at the end the facility unsupervised eview of the report and video two staff members (Stock esistant Activities Director) fity at 1:04 PM, observed in a grassy area behind the Resident #1 back into the ght minutes after the exed Unit). A review of the realed a residential area with ed approximately twenty assy area behind the facility. 1's medical record revealed the resident on 03/08/12 with mer's Disease. Staff t's cognition was severely the facility noted Resident openent from his/her home. The plan developed on a facility would monitor the plan developed on a facility would m	F	323			

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		185414	B. WIN	IG			C 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE	.	1	REET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Resident #1 was obset the Unit, staff was to see converse, and gently walk back to designate the elopement protocoming the elopement protocoming staff when they designated area with Social Services was to needed. The Social Services of interview conducted of elopement risk assess quarterly, annually, and According to the SSD behavior management related to his/her wan also completed an elopement on 03/14/12. A comprehensive admod/14/12 revealed Rebehaviors occurred desident #1's medical 1:00 PM, Licensed Procertified Nurse Aide (in a resident's room a exited the facility and review of the notes reconstruction	erved wandering away from stay with the resident, persuade the resident to ed areas with them, follow ol, and to remind visitors to were leaving the the resident. In addition, o evaluate Resident #1 as Director (SSD) stated in on 04/03/12, at 2:50 PM, that is ments were completed and as needed by the SSD. In she had developed a at care plan for Resident #1 dering behaviors and had openent assessment for the mission assessment dated sident #1's wandering aily. Ition in the nurse's notes of I record dated 03/15/12, at actical Nurse (LPN) #1, CNA) #1, and CNA #2 were the time Resident #1 courtyard. Continued vealed at 1:06 PM on cident, Resident #1 was injuries, was in no distress,	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIF _DIN(PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING			C 4/2012		
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE	1	1	REET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COME APPROPRIATE	
F 323	care "sometime close LPN #1 stated Resided during that time becamembers returned Restation and reported in facility. According to immediately placed on and the Administrator said the Assistant Admonitored the back extermained off until 4:04 family and primary cathe incident. LPN #1 no injuries as the result incident incident. LPN #1 no injuries as the result incident. LPN #1 no injuries as the result incident incident incident. LPN #1 no injuries as the result incident incident incident incident incident. LPN #1 no injuries as the result incident incid	to 1:00 PM" on 03/15/12. ent #1 must have exited use at 1:06 PM, two staff esident #1 to the nurses' the had been outside of the the LPN, Resident #1 was in "one to one" supervision, was contacted. LPN #1 ministrator came and kit door while the power 4 PM and Resident #1's re physician were notified of said Resident #1 sustained alt of exiting the facility. #1 and #2 on 04/02/12, at I, revealed the CNAs were in m when Resident #1 exited If the CNAs did not know into the courtyard doors without alarms when the to available. The CNAs and a risk for and if they had known the functioning, they would not	F	323			

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		185414	B. WIN	IG		1	C 4/2012
	OVIDER OR SUPPLIER N MANOR OF PAINTSVI	L	I	1	REET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		4/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	the staff did not know and courtyard gate to emergency generator and #4 stated they che during walking rounds shift, had not identifie have immediately rep Maintenance Departn The staff interviewed #1 had behaviors of gpushing the doors who sound. Staff also state exhibited behaviors, so resident to perform the from the exit seeking. An interview with the 04/02/12, at 2:30 PM, the exit door to the Universe not on emergen According to the Mair generator was on a time weekly basis for a "perform that remained on and Maintenance Director had remained on and Maintenance Director codes on doors were that nurses checked to routinely to ensure the addition, according to all doors in the buildir 03/15/12 after Reside unsupervised to ensure properly and stated a working condition and Maintenance Director company on 03/15/12	the back door of the Unit the Unit were not on power. LPNs #1, #2, #3, lecked the Units doors is every two hours on every d any concerns, and would orted any concerns to the ment and Administration. stated they knew Resident poing to the exit doors and ich caused the alarm to ted in the event Resident #1 staff was to assist the sks that distracted him/her behaviors. Maintenance Director on prevealed he was unaware that and the courtyard gate cy generator power. Intenance Director, the mer and was activated on a performance" test. The stated the door/lock system locked when tested. The stated the keypad changed as needed, and the doors and alarms they worked properly. In the Maintenance Director, and were checked on that I exited the building tre they were working II other doors were in If on generator power. The	F	323			

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		185414	B. WIN	IG			C 4/2012
	OVIDER OR SUPPLIER N MANOR OF PAINTSVI			1	REET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE PAINTSVILLE, KY 41240	04/0	4/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COPPREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 323	the electric company repairs until 03/30/12 Interview with the factor 04/04/12, at 10:00 had contacted the corregarding the need for and the courtyard docemergency generator stated they were not a community as the factornado damage, the "swamped" and had a had/or connect the fargenerated power beform the Administrator, As the Director of Nursin on 04/02/12, at 3:00 for the back door to the ladd not lock and/or also power failure. The Actor of the other doors in the generator power and unit and the courty are interview revealed gethe Unit door/gate on The Administrator state contacted immediated Director after Resider unsupervised and corwas unable to perform 03/30/12. In addition conducted in-service related to when the edoor of the unit and the	dity's local power company AM, revealed the facility mpany on 03/15/12 r the exit door to the Unit or to be placed on power. The company ocated in the same dility and, because of recent company had been been unable to assess cility's door/gate to ore 03/30/12. Issistant Administrator, and g (DON) stated in interview PM, that they were unaware Unit and the courtyard gate farm in the event of electrical diministrative staff stated all the facility ran on emergency they thought the door to the digate did the same. nerator power was added to 03/30/12 by an electrician. ted the electrician was y by the Maintenance of #1 left the facility offirmed the electric company of the Administrative staff training for staff on 03/15/12 fectricity was off, the exit the courtyard gate were did, and staff was to monitor	F	323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
		185414	B. WIN	G			4/2012
	ROVIDER OR SUPPLIER IN MANOR OF PAINTSVI	LLE		10	EET ADDRESS, CITY, STATE, ZIP CODE 125 EUCLID AVENUE AINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETION	
F 323	revealed a sign was punit to inform staff/re door of the Unit and tunlocked and unarmoutage to ensure the and safe. Observations of Resi 10:30 AM and 11:30 9:30 AM, 10:20 AM, a provided one to one sand escorted the resi to activities, therapies meals. An interview attempted on 03/30/1 the resident's severel unsuccessful. *The facility implement correct the deficiency -An investigation was Assistant Administrat Nursing (DON), and I determine how Resid 03/15/12. -The AADM continuo back door and the coat 1:06 PM, until the polymer of the coat 1:06 PM at 1:06 P	costed by the DON on the sidents/visitors that the back the courtyard gate were ed in the event of a power residents were monitored dent #1 on 03/30/12, at AM, and on 04/02/12, at and 11:30 AM revealed staff supervision of the resident dent throughout the facility s, and the dining room for with Resident #1 was 2, at 10:30 AM, but due to by impaired cognition, was need the following actions to continue the fo	F	3323			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION G	(X3) DATE SUF	ED
		185414	B. WIN	IG_			C 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE			REET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	J 04/0	7/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	supervision on 03/15, one supervision. -Resident #1's physic on 03/15/12 of the incompany on 03/15/12. -Resident #1's care programmed a power outage in the with all staff working and a power outage in the with all staff working and a power outage in the with all staff working and a power outage in the with all staff working and a staff workin	cian was notified at 1:30 PM cident and no new orders facility. It was notified of the incident clan was reviewed on d. In was held on 03/15/12 the unit. In the medication room door 12 to inform staff that "if the ne doors will unlock and the monitored closely." In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15 In the local power company utage on 03/15/12, at 1:15	F	323			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLETI	ED
		185414	B. WIN	G			C 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE		10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE AINTSVILLE, KY 41240	1 04/0-	72012
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -			х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	in the Unit that were a elopement risk were revised as needed to -An in-service regard gate and power outag 03/28/12 and 03/29/1 staff and CNAs that d may be "pulled" into the -A "check sheet" was document the Unit do every two hours. -As part of the facility Improvement (CQI), the monitored during shift will be monitored every staff and the results of the reported quarterly at a committee met on 03 review care plans and -The back door of the were connected to the power on 03/30/12 to functional in the even outage. This had been the Maintenance Direct the moutage of the were connected to the outage. This had been the Maintenance Direct the Maintenance Direct the Maintenance Direct the Maintenance (AADM (DON) on 03/30/12, a Assistant Administrator (Assistant Administrator)	also identified as an reviewed on 03/15/12 and ensure resident safety. Ing the Unit door/courtyard ges was completed on 2 for other licensed nursing lid not work in the Unit but the Unit to work Implemented on 03/28/12 to for alarms were monitored Is Continuous Quality the door alarm checks will be the change and the Unit doors ary two hours by the nursing of the monitoring will be the CQI meetings. The CQI (15/12 and 03/28/12 to 12 policies. I Unit and the courtyard gate the emergency generator ensure locks/alarms were to fan electrical power en scheduled on 03/15/12 by actor.	F	323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			С	
NAME OF DE	ROVIDER OR SUPPLIER	185414				04/04	4/2012
	N MANOR OF PAINTSV	ILLE		1025	T ADDRESS, CITY, STATE, ZIP CODE S EUCLID AVENUE NTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	PM, to the facility. In 04/02/12, at 11:35 A monitored the Unit d restored on 03/15/12 -Review of Resident revisions were made the incident on 03/15 -Observations of Resident revisions were made the incident on 03/15 -Observations of Resident revisions and 11:30 9:30 AM, 10:20 AM, provided one to one and escorted the resident on oscivities, therapies meals. -Interview with the A PM, and a review of care plans and the revised on 03/15/12 care plans were revised and #9). No discrep elopement care plans the "wandering/elope for all residents asset elopement/wanderin pictures, personal idenumbers. -A review of in-service the Unit on 03/15/12 monitor residents as risk for wandering/elope back door of the	restored on 03/15/12, at 4:04 nterview with LPN #1 on M, confirmed the AADM oor until the power was 2, at 4:04 PM. #1's care plan confirmed to the care plan following	F	323			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUF COMPLET	
		185414	B. WIN				C 4/2012
	OVIDER OR SUPPLIER	L		10	EET ADDRESS, CITY, STATE, ZIP CODE 125 EUCLID AVENUE AINTSVILLE, KY 41240	04/0	4/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	did not routinely work potentially be assigned Interviews conducted and #5 on 04/02/12, a AM, 11:30 AM, and 1 #2, #3, and #4 on 04/3:00 PM, and 3:10 PM in-serviced and inform Unit and the courtyard alarm in the event of be monitored if a powaddition, staff intervieresidents at risk for elemonitored at all times outage occurred. Review of the CQI m Administrator on 04/0 meetings had been hestaff (Administrator, ADirector of Nursing, N. Coordinator, and Soco 03/15/12, 03/16/12, aplans for Resident #1 assessed to be at risk behaviors. The Administrative staff/C revised, and created content and training; staff to document the gate locks/alarms we functioning. Reviews of the Door	a alarm. In-services 2 and 03/29/12 for staff that the Unit but could ad to work in the Unit. with CNAs #1, #2, #3, #4, at 9:05 AM, 9:30 AM, 10:25 2:25 PM; and with LPNs #1, 03/12, at 2:45 PM, 2:55 PM, M, revealed staff had been ned the back door of the d gate would not lock or a power outage and should are outage occurred. In wed acknowledged dopement were to be closely a, including when a power sinutes and interview with the 14/12, at 11:00 AM, revealed eld with the Administrative assistant Administrator, Minimum Data Set (MDS) ial Services Director) on nd 03/28/12 to update care and other residents a for wander/elopement nistrator also stated the QI committee reviewed, policies; reviewed in-service and developed forms for Unit door and the courtyard are monitored and Alarm Policy (reviewed by 2) Missing Persons Policy	F	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	ISTRUCTION (X3) DATE SU COMPLET	
			A. BUILDING			С
		185414	B. WING		04/0	4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTS	/ILLE	1	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE AINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	by the facility on 03/no concerns identification 04/04/12, at 10:00 had contacted the coregarding the need and the courtyard demergency generate 483.75 EFFECTIVE ADMINISTRATION/A facility must be accentables it to use its efficiently to attain of	Prevention Policy (reviewed 15/12) were conducted with ed. acility's local power company 10 AM, confirmed the facility ompany on 03/15/12 for the exit door to the Unit cor to be placed on or power. RESIDENT WELL-BEING Iministered in a manner that resources effectively and r maintain the highest , mental, and psychosocial	F 323			
	by: Based on interview review, and a review it was determined the failed to ensure the manner which enable effectively and efficitinghest practicable psychosocial well-but of nine sampled res. The facility failed to ensure policy and prelated to supervision residents who were	IT is not met as evidenced , record review, facility policy v of the facility's investigation, he facility's Administration facility was administered in a held it to use its resources hertly to attain or maintain the hotysical, mental, and heing of each resident for one hidents (Resident #1). have an effective system to rocedures were implemented her to prevent accidents for hidentified at risk for hig in the facility's locked Unit.		Past noncompliance: no plan of correction required.		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		185414	B. WIN	G			C 4/ 2012
	OVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE	.	10	REET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 490	effective system to en and alarm systems for effective in protecting assessed to be at risk facility without staff known failed to have an effective ensure the Comprehe implemented to ensure monitoring of Resider (Refer to F282 and F3). On 03/15/12 at 12:53 including the facility, and the door alarm system back door and the deactivated and not seemergency generator Resident #1, assesse for elopement (leaving knowledge), exited the traveled through the orgate without staff knowledge), exited the traveled through the orgate without staff knowledge). This failure has cause serious injury, harm, in Resident #1 and othe Immediate Jeopardy (03/15/12, and continuimplemented corrective completed prior to the	ation failed to have an asure the magnetic door lock or the locked Unit were residents who were a for elopement (leaving the nowledge). The facility also cive system in place to ensive Plan of Care was re supervision and at #1 to prevent elopement. 323.) PM, the community, experienced a power outage vistem in the locked Unit to experienced a power outage vistem in the locked Unit to experience a power. At 12:58 PM, and by the facility to be at risk go the facility without staff to back door of the Unit, courtyard, and exited the wiledge. The resident was area behind the facility within ential street and four the facility. We actions which were existed Agency's 0/12, therefore, the Jeopardy	F	490			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		185414	B. WIN	G			C 4/2012
	OVIDER OR SUPPLIER	LLE	•	10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE AINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 490	Prevention Policy (rev "Residents who are a unattended, due to co knowledge of the faci identified in a wander for elopement risk, and developed and impler Review of the Missing 03/06/12) revealed all adequate supervision An incident and investigation 03/15/12 revealed a coccurred between the 4:04 PM. Based on the courtyard were without outage and Resident unnoticed by the staff assigned to work the Practical Nurse (LPN (CNA) #1, and CNA #1 room and was not aw facility. A review of the revealed Resident #1 1:01 PM, and at 1:04 the Assistant Activitie Resident #1 walking if facility and assisted Ffacility and the Interview with LPN #1 revealed the nurse waroom by two (2) CNAs	d's Wander/Elopement vised on 01/23/12) revealed threat to leave the facility onfusion, without the lity staff" were to be velopement book, assessed and a plan of care was to be mented for those residents. By Persons policy (revised a residents should receive to prevent elopement. Compared to the series of the series of 12:53 PM and the report, the Unit door and the alarms during the power with a larms during the power with 1 exited the facility. The report revealed staff Unit on 03/05/12, Licensed of 12:53 PM and the resident with a left the series facility's video footage exited the courtyard gate at PM, Stock Control #1 and so Director observed on the grassy area behind the desident #1 back inside the opht minutes after the	F	490			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414	A. BUII B. WIN	DING			C 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTS	/ILLE		102	T ADDRESS, CITY, STATE, ZIP CODE B EUCLID AVENUE NTSVILLE, KY 41240	1 04/0	7/2012
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 490	AM and 9:30 AM revaluation another resident's rethe facility unattendent the exit door to the lowere unlocked and electric power was restated if they had knot functioning, they Resident #1 without Interviews conducte #4 on 04/03/12, at 2 and 3:10 PM reveal doors every two houthe doors were funchave reported any in Maintenance and Active they did not know the courtyard gate were emergency generated. An interview with the 04/02/12 at 2:30 PM the exit door to the lowere not on emerge Maintenance Directic company on 03/15/2 gate on emergency electric company corepairs until 03/30/1 The Administrator, Atthe Director of Nursiconducted on 03/30	#1 and #2 on 04/02/12 at 9:05 vealed the CNAs were in born when Resident #1 exited ed. The CNAs did not know Unit or the court yard doors without alarms when the not available. The CNAs bown the door alarms were would not have left the staff. d with LPNs #1, #2, #3, and :45 PM, 2:55 PM, 3:00 PM, ed they checked the Unit's ars during their shift to ensure tioning properly and would dentified concerns to diministration. Staff stated e back door of the Unit and not connected to the or. e Maintenance Director on I revealed he was unaware Unit and the courtyard gate ncy generator power. The or contacted the power 12 to get the Unit door and generator power, however the uld not make the needed	F	490			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414	B. WIN				C 4/ 2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE		10	EET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE AINTSVILLE, KY 41240	1 04/0	7/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 490	courtyard gate were remergency generator unlocked and without outage. In addition, the Assistant Administration acknowledged facility Resident #1's plan of unsupervised and, as resident left the building are identified in the facility implement correct the deficiency. An investigation was Assistant Administration Nursing (DON), and Modetermine how Reside 03/15/12. The AADM continuous back door and the contact at 1:06 PM until the period of 15/12, at 4:04 PM. Resident #1's family incident on 03/15/12, member came to the #1 until the power was supervision on 03/15/15/12 of the incomplete in the period of 15/12 of 15/12 of the incomplete in the period of 15/12 of 15/12 of the incomplete in the period of 15/12	not connected to the power source and were alarms during a power he Administrator, the or, and the DON staff had failed to follow care, had left Resident #1 a result, were unaware the ng. Inted the following actions to: Initiated immediately by the or (AADM), Director of Maintenance Director to ent #1 exited the building on usly monitored the Unit's urtyard gate from 03/15/12, ower was restored on member was notified of the at 1:10 PM, and the family facility to sit with Resident is restored. Deed on one to one in the initial remains on one to it in was notified at 1:30 PM sident and no new orders	F	490			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185414		G			C)4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTS	/ILLE	•	102	T ADDRESS, CITY, STATE, ZIP CODE 5 EUCLID AVENUE NTSVILLE, KY 41240		-
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 490	-An in-service regarda power outage in the with all staff working -A sign was posted in the Unit on 03/15/electricity goes out, residents should be -The AADM contact to report the power of the Unit in order to remergency power gradients and swere checked on 03 found to be locked, properly on generated door to the Unit and -The care plans of the Unit that were elopement risk were revised as needed to -An in-service regardate and power out 03/28/12 and 03/29/	plan was reviewed on ed. ding what to do in the event of the Unit was held on 03/15/12 the unit. on the medication room door 12 to inform staff that "if the the doors will unlock and the monitored closely." ed the local power company outage on 03/15/12, at 1:15 Director contacted the electric 12 to evaluate the door/gate in have them placed on enerator. tairwell doors in the building 1/15/12, at 1:30 PM, and armed, and functioning or power, except the back	F	490			

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	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED						
			A. BUIL	.DING			С
		185414	B. WIN	G		04/0	4/2012
	ROVIDER OR SUPPLIER	/ILLE		102	ET ADDRESS, CITY, STATE, ZIP CODE 25 EUCLID AVENUE INTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 490	document the Unit devery two hours. -As part of the facilit Improvement (CQI), monitored during she will be monitored evitaff and the results reported quarterly at committee met on 0 review care plans are. -The back door of the were connected to e on 03/30/12 to ensure functional in the everoutage. This was so Maintenance Director. **The surveyor valid taken by the facility of the facility of the facility of the facility of the facility. In 04/02/12, at 11:35 A AADM monitored the was restored on 03/10-Review of Resident.	the Unit to work s implemented on 03/28/12 to door alarms were monitored y's Continuous Quality the door alarm checks will be ift change and the Unit doors ery two hours by the nursing of the monitoring will be the CQI meetings. The CQI 3/15/12 and 03/28/12 to and policies. The Unit and the courtyard gate emergency generator power re locks/alarms were ant of an electrical power heduled on 03/15/12 by the or. The dated the corrective action as follows: Administrator, Assistant M), and Director of Nursing at 10:25 AM, revealed the attor monitored the Unit's back gate from 03/15/12, at 1:06 arestored on 03/15/12, at 4:04 anterview with LPN #1 on M, confirmed the fact that the te Unit door until the power	F	490			

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED					
		185414					C 04/2012
	ROVIDER OR SUPPLIER	ILLE	•	1025	F ADDRESS, CITY, STATE, ZIP CODE EUCLID AVENUE NTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 490	10:30 AM and 11:30 9:30 AM, 10:20 AM, provided one to one and escorted the rest to activities, therapid meals. -Interview with the APM, and a review of care plans and the revised on 03/15/12 care plans were reviaccuracy (Residents and #9). No discrepelopement care plans the "wandering/elopefor all residents asselopement/wandering pictures, personal idnumbers. -A review of in-service the Unit on 03/15/12 monitor residents as risk for wandering/elmonitor the back docourtyard gate in the because the doors vollaservices continue for staff that did not could potentially be interviews with CNA #7,#8, and #9, LPNs 04/02/12, at 9:05 AM		F	190			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		185414	B. WIN	G			C 4/ 2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSVI	LLE	1	1	REET ADDRESS, CITY, STATE, ZIP CODE 025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 490	04/03/12, at 2:15 PM, PM, 3:00 PM, and 3:1 been in-serviced and the Unit and the court alarm in the event of a be monitored if a pow addition, staff intervieresidents at risk for el monitored at all times outage occurred. -Review of the CQI m Administrator on 04/0 meetings had been he staff (Administrator, A Director of Nursing, M Coordinator, and Soc 03/15/12, 03/16/12, a plans for Resident #1 assessed to be at risk behaviors. The Administrative staff/Corevised, and created content and training; a staff to document the gate locks/alarms were functioning. -Reviews of the Door the facility on 03/15/1 (revised by the facility on 03/15	2:25 PM, 2:45 PM, 2:55 0 PM, revealed staff had informed the back door of yard gate would not lock or a power outage and should er outage occurred. In wed acknowledged opement were to be closely, including when a power inutes and interview with the 4/12, at 11:00 AM, revealed eld with the Administrative assistant Administrator, linimum Data Set (MDS) ital Services Director) on and 03/28/12 to update care and other residents a for wander/elopement inistrator also stated the CI committee reviewed, colicies; reviewed in-service and developed forms for Unit door and the courtyard re monitored and Alarm Policy (reviewed by 2), Missing Persons Policy on 03/15/12), and revention Policy (reviewed 5/12) were conducted with the facility's local power company AM confirmed the facility	F	490			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SUF COMPLET	
		185414	B. WIN	G			C 4/2012
	ROVIDER OR SUPPLIER N MANOR OF PAINTSV			1025	T ADDRESS, CITY, STATE, ZIP CODE 5 EUCLID AVENUE NTSVILLE, KY 41240	04/0	4/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		JLD BE	(X5) COMPLETION DATE		
F 490	' '	or the exit door to the Unit oor to be placed on	F	490			